Memorial Colon and Rectal Surgery

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:______________________________ Medical Record #/ ID Number:__________________

Date of Birth:____________________ Social Security Number:______________________

Section A: This section is to be filled out by the patient

I hereby authorize **General Surgery Associates** to use/disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or health care professional, that my information may no longer be protected from disclosure by state or federal law.

List the specific information that is authorized for disclosure:

Date of Service/Encounter to be released:______________________

- Anesthesia
- History/Physical
- Orders
- Itemized Bill
- Consultation
- Imaging Reports
- Outpatient
- Account of Disclosure
- Discharge Summary
- Laboratory
- Pathology
- Entire Record
- EKG's
- Medication
- Progress Notes
- Other
- Emergency
- Nursing
- Billing Records
- X-ray films
- Face Sheets
- Surgeries/Procedures

Information Released to/from: Name:________________________________

Address:________________________________

City/State/Zip______________________________

Phone/Fax:________________________________

Section B: This section to be completed by Providers if disclosure is for own purposes:

Purpose of Disclosure: ____

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Facility/Practice will receive financial or "in-kind" compensation for the use/disclosure of the information described above?________________________________

Section C: Patient must read and complete information in this section

- I understand my health care will not be affected if I do not sign this form
- I understand that this authorization will expire on ________________
- I understand that I may revoke this authorization at any time by notifying **General Surgery Associates** in writing, except to the extent that has already taken in reliance of the previous authorization period.

I hereby authorize the use or disclosure of my individually identifiable health information as described above, I understand that unless restricted by individual state laws, that this information may contain information about HIV, AID, venereal disease or mental health disorders. I understand that the exception to this authorization applies to (in accordance with 41 CFR part 2) records containing drug/alcohol abuse or therapist psychiatric notes. These records types require a separate authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations.

Signature of Patient or Patient Representative:____

If not signed by patient, please indicate relationship

- Parent or Guardian of minor
- Guardian/Conservator of incompetent patient
- Beneficiary/Representative of deceased patient

General Surgery Associates

I, ____ am missing the following at my visit today __________________________ .

Insurance Card

Identification Card

I understand that I need to provide proof at every visit. I agree that I am responsible for getting the proper information back to this office. I understand that I can and will be held financially responsible if o fail to do so in a timely manner.

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Patient Signature Date